

NOXAFIL[®], VFEND[®]
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM



BlueCross BlueShield
of Illinois

ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:		City, State, Zip	Patient Telephone:

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:	
Medication Requested:	
Dosing Schedule:	Quantity per Month:
1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment started? _____	
2. Please indicate the pathogen for the patient's infection: <input type="checkbox"/> Aspergillus sp. <input type="checkbox"/> Fusarium sp. <input type="checkbox"/> Candida sp. <input type="checkbox"/> Zygomycetes sp. <input type="checkbox"/> Scedosporium apiospermum <input type="checkbox"/> other _____	
3. Is the patient immunocompromised due to hematopoietic stem cell transplant (HSCT), graft-vs-host disease (GVHD), or hematologic malignancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is the requested agent to be used for prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____ _____	
6. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____ _____	

Please fax or mail this form to:
 Blue Cross and Blue Shield of Illinois
 c/o Prime Therapeutics LLC, Clinical Review Department
 1305 Corporate Center Drive
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.285.9426

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